HOME/COMMUNITY-BASED SERVICES
ELIGIBILITY DETERMINATION FORM

TO BE COMPLETED BY PROVIDER, THEN SENT TO DIVISION OF DEVELOPMENTAL DISABILITIES QDDP/QUALIFIED STAFF

_____

Provider Name Address Phone Number

_____

Applicant's Name Social Security Number Medicaid Number

_____

Address Phone Number

Date of birth_____

Is applicant a recipient of SSI? **[ ] Yes [ ] No**

Date the DSS EA 265e or the DSS EA 240 submitted to DSS _____

I. ARE THE FOLLOWING ATTACHED?

1. Current Psychological **[ ] Yes [ ] No**
2. ICAP eligibility form (DHS-DD-ICAP) **[ ] Yes [ ] No**
3. Provisional Plan of Care (Significant Change Request form) **[ ] Yes [ ] No**
4. HCBS Waiver Rights (DHS-DD-717) **[ ] Yes [ ] No**

PROVIDER AUTHENTICATION _____

Case Manager Date

II. TO BE COMPLETED BY UTILIZATION REVIEW TEAM

1. Current psychological attached? **[ ] Yes [ ] No**
2. Applicant meets criteria as indicated in ICAP form? **[ ] Yes [ ] No**
3. Provisional Plan of Care designates services requested? **[ ] Yes [ ] No**
4. HCBS Waiver Rights (DHS-DD-717) signed? **[ ] Yes [ ] No**
5. Applicant is eligible for ICF/IID (HCBS) services? **[ ] Yes [ ] No**

URT AUTHENTICATION _____

DHS DDD QDDP/QUALIFIED STAFF Date